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ABSTRACT

Education can be regarded as an intervention, a treatment, and a potential positive influence on the health of an accessible group of children and youth ages 3-18. Education can have a positive effect upon health by modifying prominent behaviors established during youth that result in preventable morbidity and mortality during both youth and adulthood. These behaviors include: failure to use seat belts; drinking or drug use that results in accidents, homicide, or suicide; unprotected sexual intercourse that results in unwanted pregnancy or sexually transmitted diseases; tobacco use; excessive consumption of fat, calories, and sodium, and insufficient consumption of fiber; and insufficient exercise. In spite of the evidence that school health education can change health behavior, health instruction is either nonexistent or seriously inadequate for the majority of students in the United States. To remedy this situation, national policy that supports comprehensive school health education is needed. A list of National Health/Education Consortium members and a description of the formation and goals of the consortium are appended. (IAH)

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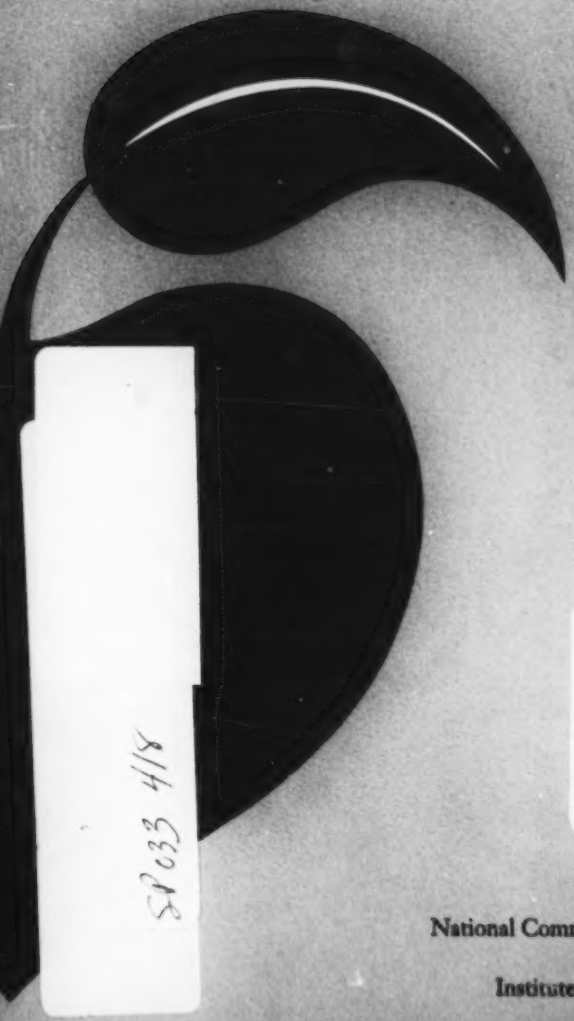
A Practitioner's Perspective on the Interrelationship of the Health and Education of Children

by

Ramon C. Cortines
Superintendent of Schools
San Francisco, CA



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National Commission to Prevent Infant Mortality
Institute for Educational Leadership

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A Practitioner's Perspective on the Interrelationship of the Health and Education of Children

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Introduction

The following paper was presented at a meeting of the National Health/Education Consortium on May 29, 1990, in Washington, DC. The presentation entitled, "A Practitioner's Perspective on the Interrelationship of the Health and Education of Children" was given by Ramon Cortines, Superintendent of Schools in San Francisco, CA.

An important theme of the National Health/Education Consortium is reflected in this presentation. That is, children must be taught to maintain and improve their own health, if they are to maximize their learning potential. Dr. Cortines' paper outlines the principal benefits which can be gained through good health education, the status of health education courses around the nation, and proposals about how the education system should provide health education in the schools.

A Practitioner's Perspective on the Interrelationship of the Health and Education of Children

I have been asked to talk about the interrelationship of the health and education of children from the perspective of a practitioner — an educator. During the rest of today and tomorrow morning, we will hear presentations about biological and environmental factors that impact upon a child's potential for learning. We will hear about the increasing numbers of impediments to normal growth and development before birth, during infancy and in early childhood. We will discuss the effects of drug and alcohol use during pregnancy, low birthweight and prematurity, negative environmental factors, and a wide variety of dysfunctional physical and emotional health conditions of children in the United States. In other words, we will have an extensive review of the outcomes of physical, emotional, and social factors upon the potential of our children and youth.

I am an educator. I am a Superintendent of a large urban school district with a diverse population of students who are 85% nonwhite. The majority of our new enrolles have at least one parent who was not born in the United States: many of our students were themselves born in another country including the Third World countries. All communications sent home to parents are translated into a minimum of four languages. Our student population includes young people who have been exposed to all of the negative biological and environmental factors that will be discussed during this conference and probably some that will not be mentioned.

As a professional educator, I will challenge you to explore the interrelationship of education and health quite differently. I suggest that we look at education as an intervention — as treatment — as potential positive influence on the health of an accessible group of children between the ages of 3 and 18. Education can have a positive effect upon the health status of students. The interrelationship between health and education I will address is the potential positive impact of education upon health during youth and adulthood.

I will support the following statements in my presentation:

1. Education can have a positive effect upon health.

2. Health instruction is either nonexistent or seriously inadequate for the majority of students in schools in the United States.

3. There is evidence that school health education can change health behavior.

4. National policy that supports comprehensive school health education is needed.

Education Can Have a Positive Effect Upon Health.

The prominent behaviors established during youth that result in preventable morbidity and mortality during both youth and adulthood are:

- Failure to use seat belts;
- Drinking or drug use that results in accidents, homicide and suicide;
- Unprotected sexual intercourse that results in unwanted pregnancy, sexually transmitted diseases (including HIV infection and AIDS);
- Use of tobacco;
- Excessive consumption of fat, calories and sodium and insufficient consumption of fiber;
- Insufficient exercise.

Last week, we buried a young man who died of complications of AIDS — he was diagnosed at the age of 16. That death could have been prevented with education. Three weeks ago, one of our high school students committed suicide. An elementary student was accidentally shot and killed by another student who was playing with a gun. Another elementary school student was killed by a car when crossing the street. A middle school student was a victim of a drive-by shooting. This all happened in the first five months of 1990. All of these deaths were preventable. Those are just the deaths. We don't have any way of collecting data about the number of students who will die or become dysfunctional as a result of tobacco, alcohol or drug use. But we know it is preventable. We have no way of knowing how many of the young women in our schools will use tobacco, crack, or alcohol while pregnant — now or in the future. But we know it is preventable. We have no way of knowing how many of the young women in our schools will use tobacco, crack, or alcohol while pregnant — now or in the future. But we know it is preventable. We have no way to calculate the number of students who will have cardiovascular disease because of their diet and lack of exercise. But we know it is partially preventable. We have no idea how many of our students currently enrolled in our schools will die of complications of AIDS, but we know it is preventable.

Education could have a positive effect on health. Instruction is an effective intervention in addressing the behaviors that result in some of our most serious health problems and frequently, unnecessary death.

Health Instruction is Either Nonexistent or Seriously Inadequate for the Majority of Students in Schools in the United States.

Despite the obvious need to change health behavior and the evidence that instruction can change health behaviors, health instruction is either nonexistent or seriously inadequate for the majority of students in schools in the United States. About 5% of the nation's schools provide a comprehensive K-12 program of health instruction (U.S. Public Health Service, 1988).

The average number of hours of health instruction for a student in the United States is 13.8 hours per year in grades K-12. To put that in perspective, a typical semester is 90 hours, a quarter is 45 hours, 27 hours is a four-week course and 13 hours is 2 1/2 weeks of instruction. Further, the instruction is most often provided by a teacher who is not credentialed or professionally prepared in the subject. Muse for just a minute about how well our students would be able to read, write and calculate if Reading, Writing and Arithmetic were taught only 2 1/2 weeks a year — and primarily by teachers who were not trained in the subjects.

Only 53% of the states require health education in public schools. And even in those states that require health education, the average number of hours of instruction for a student is 27 hours per year — and that instruction is most often provided by a teacher who has no training to teach the subject.

California is one of those states that does not require health education. As in most states there is a patchwork of education codes and administrative initiatives that require or support specific topics to be addressed. But there is no requirement for instructional time devoted to health topics. There is no accountability for what students learn about health and no standardized testing about health knowledge.

If, as a nation, we provided sequential, planned health instruction in all our preschools and K-12 systems for a generation, we could substantially change the health behavior of our nation. Sequential, planned health instruction is not a reality in our schools today. The reality is a multitude of problem-specific, reactionary, short term uncoordinated and expensive programs about health problems of current public interest.

There is Evidence that School Health Education Can Change Health Behavior.

I've suggested comprehensive health education in our preschool through high school systems where we have access to the overwhelming majority of the population between the ages of 3 and 18. Would it work?

This reminds me of the challenge presented to Moses as he led the Israelites out of bondage in Egypt. With the oppressors in hot pursuit, Moses was confronted by the Red Sea. He called his bridge builders who said the task was impossible as they had not done an Environmental Impact Study and could not complete the task in less than a couple of years. Exasperated, he called his ship builders who again cited the barriers:

excessive costs, lack of building materials, union contracts and lack of skilled craftsmen. With the Egyptians rapidly approaching, he called his Public Relations Consultant and pleaded for direction. The PR man suggested that he wave a stick over the water and separate it just enough to allow his people to start walking across the floor of the sea. Then after getting part of the way across, he suggested he wave the stick again so that the water would wipe out the Egyptians who were following. Moses said, "Will that work?" The PR man said, "I don't know but if it does, I'll get you three pages in the Old Testament!"

Unlike the suggestion given to Moses, there is clear evidence that comprehensive school health education would work. This is not just a PR gimmick. There is a body of research that supports the effectiveness of instruction in, not only changing knowledge, but also changing attitudes and behavior related to health.

The 1986 School Education Evaluation conducted in collaboration with the Centers for Disease Control (CDC) reported significant health behavior changes after 30 hours of instruction and stabilizing of those behavior changes after 50 hours of instruction. The data from that study suggest that in 1984, if all fourth through seventh grade student in United States schools had been exposed to the health curricula used in the study, 146,000 students would not have begun to smoke in the seventh grade (MMWR, September 26, 1986).

Findings of a study conducted by the Metropolitan Life Insurance Foundation in 1988 indicated that after one year of health instruction 43% of students have a drink sometimes or more often. That proportion drops to 33% after three years of health instruction. After one year of health instruction, 20% of students smoked cigarettes sometimes or more often as opposed to 14% among those with three years of health instruction. In contrast to 13% of students having received health education for one year who have taken drugs a few times or more, only 5% of those with three years of health education have done so. The proportion of those who have ridden with a driver who has been drinking decreased from 70% for students with one year of health education to 63% for students with three years of health education.

More recently a Rand Study reported significant changes in smoking and other drug use after 18 weeks of instruction with booster sessions of instruction. Deaths among teenagers during the graduation period has been substantially reduced by sober graduation programs. In South Carolina, a health education program to reduce unintended adolescent pregnancies showed a 54% decrease in the pregnancy rate for students exposed to education as intervention. In a Minnesota smoking prevention education program, only 3.8% of the students in the instructional program started smoking while 12.3% of the comparison group started smoking. The evidence that health education works is overwhelming but national policy is needed.

National Policy that Supports Comprehensive School Health Education is Needed.

In Objectives for the Nation being developed by the U.S. Public Health Service for the Year 2000, there will be an objective that reads something like this:

> *"By 2000, there will be a 50% increase in the proportion of the Nation's elementary and secondary schools that provide a planned and sequential Kindergarten through grade 12 program of comprehensive school health education."*

The baseline being used is 5%.

In order to have a comprehensive school health instructional program for students in preschool through high school, we need national and state level policy about course requirements and instructional time. In the states that currently have a time requirement for instruction, the number of hours required varies from 4 1/2 to 66 hours per year. In the states that have a high school course in health as a graduation requirement, the hours of instruction for that course vary from 60 to 150 hours (School Health in America, ASHA, 1989). In the nation's elementary schools, 81% of the teachers have no special training in health education; in the middle and senior high schools only about one half of the health education classes that do exist are taught by certified health education teachers (Met Life, 1985).

We could use the millions of dollars allocated from tax dollars for schools to conduct the war on drugs, alcohol and tobacco use, and the millions of dollars for education to prevent HIV infection and AIDS, and the millions of dollars spent to prevent unintended pregnancy, genetic disorders, and sexually transmitted diseases, and other dollars for prevention of specific health problems to fund a comprehensive preschool through high school health instruction program taught by trained teachers. During those 12 to 15 years, we could have a sequence of age-appropriate instruction with a focus on developing the personal and social skills needed to make health promoting decisions, resist peer pressure, communicate personal needs and feelings, be assertive, nurture self-esteem, get out of dangerous situations, and encourage peers who make health promoting choices.

We need national policy so that we can use education in our schools to reduce:

- Failure to use seat belts;
- Drinking or drug use that results in accidents, homicide and suicide;
- Unprotected sexual intercourse that results in unwanted pregnancy, sexually transmitted diseases (including HIV infection and AIDS);
- Use of tobacco;
- Excessive consumption of fat, calories and sodium and insufficient consumption of fiber;
- Insufficient exercise.

Education can have a positive impact on the nation's health. Let's try it. If it works, it will get three pages in the Journal of Public Health or the Journal of the American Medical Association.

National Health/Education Consortium Members

American Academy of Family Physicians
American Academy of Pediatrics
American Association of Colleges for Teacher Education
American Association of School Administrators
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American Federation of Teachers
American Hospital Association (MCH Section)
American Medical Association
American Nurses Association
American Public Health Association
American School Health Association
Association for the Care of Children's Health
Association for Supervision and Curriculum Development
Association of American Medical Colleges
Association of Maternal and Child Health Programs
Association of State and Territorial Health Officials
Council of Chief State School Officers
The Council of Great City Schools
Healthy Mothers, Healthy Babies Coalition
NAACOG - The Organization for Obstetric, Gynecologic and Neonatal Nurses
National Alliance of Black Educators
National Association of Children's Hospitals and Related Institutions
National Association of Community Health Centers
National Association of Elementary School Principals
National Association for Partners in Education
National Association of Pediatric Nurse Associates and Practitioners
National Association of Public Hospitals
National Association of School Nurses, Inc.
National Association of Secondary School Principals
National Association of State Boards of Education
National Center for Clinical Infant Programs
National Coalition of Hispanic Health and Human Services Organizations (COSSMHO)
National Community Education Association
The National PTA
National Education Association
National Medical Association
National Perinatal Association
National Rural Health Association
National School Boards Association
National School Public Relations Association

National Health/Education Consortium

Good health is a significant determinant of a child's ability to learn and succeed in school. The health and education sectors, however, have historically approached programs and services for children from different perspectives. Recognizing the need for better integration of health and education programs for children, the National Commission to Prevent Infant Mortality and the Institute for Educational Leadership organized the NATIONAL HEALTH/EDUCATION CONSORTIUM.

The project has brought together leaders from over 40 national health and education organizations, representing 11 million constituents, to bridge the separate worlds of health and education into unified action for children. Promoting the full potential of children and providing them with the best opportunities for success will require changes in the systems which currently provide health and education services. Reforms are needed to develop more collaborative and cohesive policies, unify agencies and funding streams, and provide a more comprehensive approach to children's programs.

Toward this end, the NATIONAL HEALTH/EDUCATION CONSORTIUM's activities focus on three major goals: to improve public policy in addressing the need for a better coordinated health and education delivery system; to strengthen communication and dissemination of information between health and education programs and policymakers; and to identify exemplary program models and practices which integrate health and education. Consortium members are working to identify a series of action steps to implement these objectives at the federal, state and local levels. Town meetings involving educators, health professionals, policymakers, administrators, community leaders, advocates and parents will be held throughout the country in an effort to promote community health/education cooperative initiatives.

The NATIONAL HEALTH/EDUCATION CONSORTIUM began in May 1990. The foundation of the Consortium's efforts can be found in the report, *Crossing the Boundaries between Health and Education*, which documents clinical research and programs that exemplify the relationship between children's health and their learning potential. To complement this report, the Consortium is releasing a series of papers which focus on various topics relating to health and education.

The NATIONAL HEALTH/EDUCATION CONSORTIUM is supported by The Prudential Foundation. Additional support has been provided by Glaxo, Inc., the Irving Harris Foundation, the Pillsbury Foundation, the U.S. Department of Health and Human Services, and the U.S. Department of Education.

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